Rheumatic Disease Treatment Services Available to the Family Physician

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ARTHRITIS certainly is not the dreadful, incurable disease with no satisfactory treatment other than aspirin that the general public thinks it is. Distressingly often we see patients with inactive, ("burned out") disease. Because they have had either no treatment or inadequate treatment during their active disease state they are left badly crippled. We still have no cure for rheumatoid arthritis but, as nature often provides a spontaneous cure or remission, it is important that we emphasize treatment to prevent deformity.

And there are treatments which can effectively suppress the activity of disease in many patients. The problem here is that the most effective drugs also often have the most serious side effects. The best example – cortisone – may provide dramatic relief and a sense of wellbeing but is commonly associated with serious side effects, and is difficult to withdraw. An optimal program of management balances therapeutic risk with its effectiveness.

Table I.
Services available to Physicians for the Care of Rheumatic Diseases.

Category	Services	
Hospital	– Rheumatic Disease Units	
	General Hospitals.	
Outpatient	– Arthritis Clinics	
	Rheumatologists	
	Other Consultants	– Internal Medicine
		Orthopedic Surgery
		Physical Medicine
		Psychiatry.
Physiotherapy	– in the hospital	
	as an outpatient	
	in the home	
Social Workers		
Services of the Canadian Arthritis and Rheumatism Society		

Rheumatic Disease Unit (RDU)

The advent of specific RDUs as part of university departments of medicine within teaching hospitals represents a step forward in the care of patients with rheumatic diseases. The RDUs serve as centres for specialized care of arthritic patients. More important, they enhance rheumatology teaching to medical and paramedical students and provide a nucleus of material and workers for further research in rheumatic diseases.

The RDUs have developed gradually over the past 50 years. Traditionally, spas have been centres where large numbers of patients gathered. In 1912, Landesbad, a spa in Aachen, Germany, established a special hospital for rheumatic diseases, and since that time many other European spas have established medical facilities for arthritic patients. I have visited hospitals at Bath in England and Bad Ragaz in Switzerland and found that their therapy techniques differ from those used elsewhere only in that they also take into account the psycho-therapeutic advantages of mineral baths.

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The need for arthritis units as departments of general hospitals associated with schools of medicine was first recognized in Britain in the 1930s. During World War Two, military hospitals set up such units and, after the war, permanent units were established in Edinburgh, Manchester and Taplow. In Canada the wartime Armed Forces Arthritis Unit at St. Thomas, Ont., was transferred to Sunnybrook Veterans' Hospital in Toronto and a similar unit developed later at Shaughnessy Veterans' Hospital, Vancouver.

The RDUs as presently found in Canada, arose from proposals to the Royal Commission on Health Services made by the Canadian Arthritis and Rheumatism Society which recommended the establishment of 25 or more centres in relation to regional teaching hospitals across Canada. The aims of these units were:

1. To establish a unit for the study of rheumatic diseases, as well as the prolonged active treatment and rehabilitation of patients suffering from these diseases.
2. To demonstrate the highest standard of medical care for patients requiring such treatment and to restore or maintain their state of personal self-sufficiency.
3. To provide the resources necessary for continuing intensive clinical investigation and research.
4. To supplement and enhance facilities for undergraduate and graduate instruction in medicine, physical and occupational therapy, public health and social work.

Government-sponsored hospital insurance plus strong support from CARS has since resulted in the formation of units in Vancouver, Edmonton, Saskatoon, Regina, London, Hamilton, Toronto, Kingston and Halifax. Several other Canadian medical schools have units planned for the future.

Table 2.
Functions of a Rheumatic Disease Unit

Function	
Education	– Public
	Professional
	Patient
Research	– Basic
	Clinical
	Social
Treatment	– Medical-Surgical
	Nursing
	Physical Therapy
	Social Work
	Education and Presentation

These functions of Rheumatic Disease Units can be broken down into three major areas: education, research and treatment. These boundaries, however, are artificial with a lot of overlap. For example, the doctors, nurses, therapists and social workers who are involved in treatment are also involved in educating other medical and allied personnel plus the patients, and frequently are involved in several of the Unit's research programs.

Much Neglected Field

Education in rheumatic diseases has long been a much neglected field in medical schools. A major reason for this is the relatively small number of rheumatological disorders admitted to general medical beds. The RDU provides a large number of rheumatological patients in one area. Any students having the opportunity to rotate through these units might therefore have a better opportunity of seeing these disorders and learning the fundamentals of treating them. This greater exposure also attracts a large number of physicians into this field of postgraduate study. At any one time, over half the patients in a Unit are likely to be suffering from rheumatoid arthritis. Over the period of a few months, however, there are few collagen, protein and metabolic problems that are not seen. In addition, since rheumatoid arthritis is a chronic disease, patients tend to have several other medical problems.

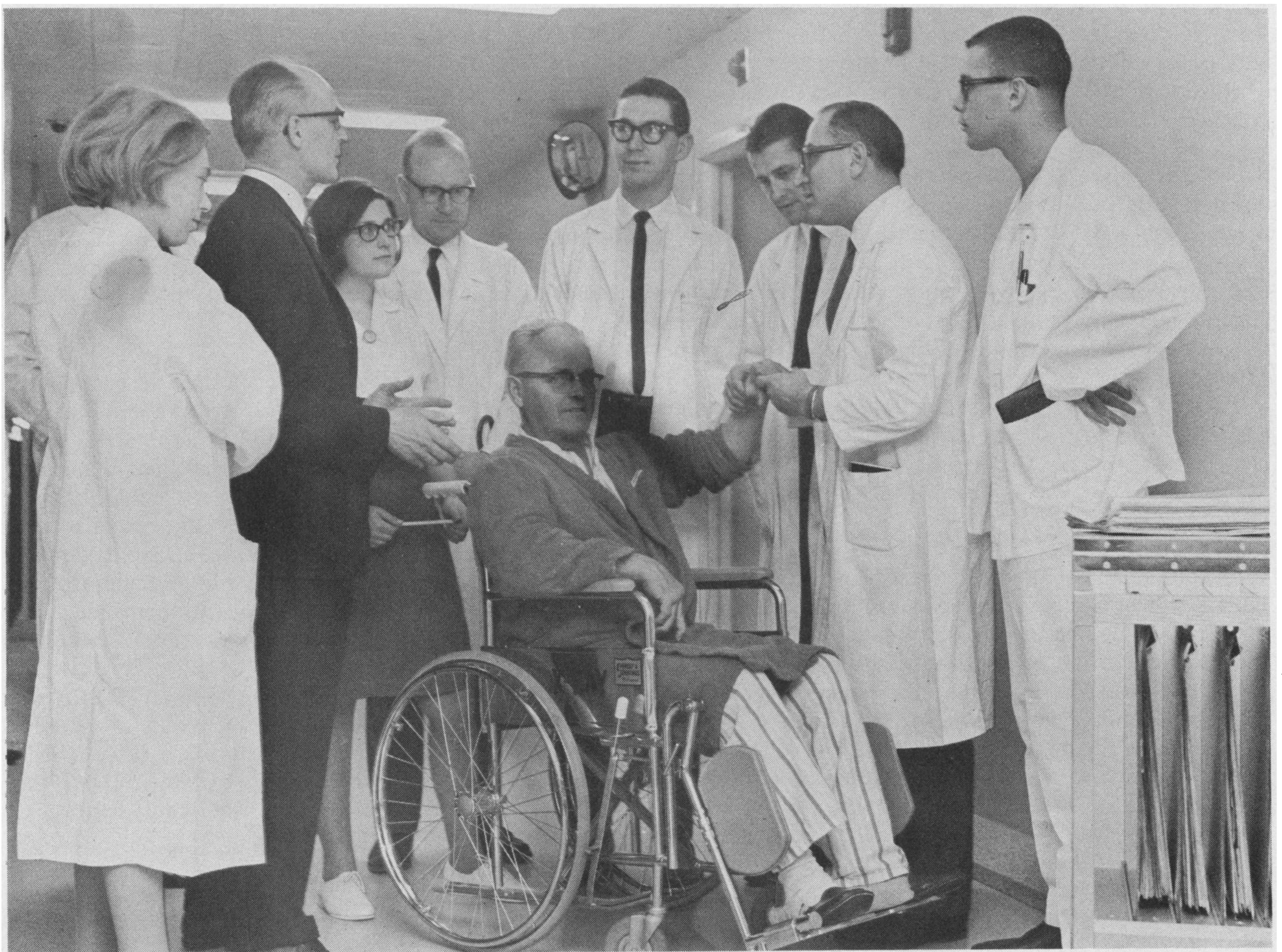
A further role of RDUs in education should be to sponsor half day to three-day refresher courses in rheumatic diseases for physicians and physiotherapists. Units are a good location, too, for teaching nurses, physiotherapists and social workers as well as physicians in other medical specialty groups such as orthopedic surgery, physical medicine, and psychiatry.

In addition to professional education, education of the patient seems to be more effective in a segregated RDU, where much of the education comes from talking with fellow patients about how they each handle their various problems. Periods when a large number of patients are together using wax baths for the hands and feet, or doing hand exercises are particularly useful. Nurses, physiotherapists and social workers trained in rheumatic diseases can run very effective courses of formal and informal education in these disorders.

Research Programs

Rheumatic Disease Units often have active research programs which may include scientific research and more clinically oriented projects. When large numbers of patients with the same disease are in one area more can be learned of the natural history of that disease and of its response to various therapeutic regimens.

The main reason for referring a patient to an RDU, however, is for treatment and rehabilitation. These Units have several advantages over general hospitals: they provide



This photograph exemplifies the inter-disciplinary, or team approach, to the rheumatic diseases in a Rheumatic Disease Unit. Included in "rounds" at the University of Toronto Rheumatic Disease Unit (Wellesley Division) is a medical social worker, a physiotherapist, physicians in-training, and rheumatologists.

segregated beds specifically for patients with rheumatological disorders, insuring that people who would otherwise be competing with acutely ill patients for hospital beds are admitted directly to hospital rather than being relegated to a less satisfactory alternative of outpatient care. In addition, in general medical wards there may be a problem in communication between the medical, nursing, physiotherapy and social work members of the therapeutic team, particularly when these members have been pre-occupied with the problems of patients more acutely ill than those suffering from arthritis.

Frequently, medical and paramedical personnel who are only occasionally exposed to rheumatoid arthritis are themselves afraid of, and therefore discourage, patients with this disorder. This fear can only be overcome by education and experience in observing the natural course of the disease. Nurses in these units learn to treat the RA patient in a less hurried and more reassuring manner that constitutes important therapy in itself. They may also obtain information which the patient hasn't given his physician but which will help them understand that particular patient's problem. Physiotherapy is better within these units, since in addition to having therapists who know, understand and can teach patients and other therapists about rheumatic diseases, there are more of them. In Ontario, for example, there is one physiotherapist allowed for every 30 or more hospital beds, but within the RDUs there is one authorized for every six patients. Daily ward exercises and hand classes can be better supervised – and there's still time for education of the patient.

Rheumatic Disease Units can provide optimal, hospitalized patient care. They are equipped to handle all types of rheumatic disease, and provide professional and patient education as well as basic, clinical and social research. Due to better understanding among medical and paramedical staff of the special problems involved in treatment of arthritic patients, care tends to be better in RDUs than in non-segregated units. And as the number of patients rehabilitated to a productive, more self sufficient life increases, so do economic benefits perhaps to a greater extent than the costs expended in operating these units.

Family physicians who are interested in having a patient admitted to an RDU should contact the Unit closest to them or they can write their local division of CARS for information.

The General Hospital

In spite of these comments on Rheumatic Disease Units there is still a place for the general hospital in the treatment of rheumatic diseases. Diagnosis of collagen disorders other than RA can often be done equally quickly and well in these hospitals. And if the physician is sufficiently confident about therapy, it can be readily effected. A doctor who will take time to talk to his patients and to the medical personnel caring for them can assure treatment which is as good, or almost as good, as that obtained in RDUs. The chief problem here is that adequate knowledge and experience in the treating of rheumatic diseases is required. A well trained rheumatologist can usually overcome a general hospital's shortcomings, but this is often more difficult for other physicians.

The major advantages are that the patient does not have to adapt to a new group of strange doctors and he is admitted to a hospital nearer to his home.

The Arthritic Clinic, The Rheumatologist and Other Consultants. The family physician who wants a consultation on his patients with rheumatic diseases is faced with the choice of referring them to an arthritis clinic attached to a university hospital (where there may or may not be an RDU), a rheumatologist, a general internist, an orthopedic surgeon or a consultant in physical medicine. His choice will depend to some extent on the availability of these various consultants and whether or not the patient has been previously admitted to an RDU.

Arthritic clinics attached to RDUs show many of the advantages ascribed to these Units. Their patients may be used in research studies on the course of their disease, or on their response to experimental forms of treatment. If so, this is not done without the patient's understanding and consent and the patient in return is rewarded by close supervision of his disease and continuing education about it. He also has the benefit of physio-therapists and social workers specially trained in rheumatic disease problems. Drawbacks are that the clinics are often some distance from the patient's home, he does not always see the same physician and he may have to wait longer at each visit. The arthritic clinics at hospitals which have no RDUs are more apt to function in a manner similar to a rheumatologist's office. They are particularly useful when a patient has previously been admitted to that hospital. Also they are often the site of the only available rheumatologist.

Patients sent to a rheumatologist's office, if later admitted to hospital, are more likely to be admitted to the hospital that rheumatologist is associated with, but many cases arise when he will feel that patients can be better treated in a RDU and he can arrange this. Generally speaking, unless other considerations are present, the patient is often best sent to the closest available outpatient clinic or rheumatologist. Some cases require the services of orthopedic or plastic surgeons, physiatrists or psychiatrists. These, however, are also often best channelled through a rheumatologist.

Physiotherapy Services

Availability of these services depends on the community the physician lives in. The Canadian Arthritis and Rheumatism Society endeavors to provide these in all areas of this country. Services are almost always available for hospitalized patients. Outpatient services either at the local hospital or at private physiotherapy clinics are generally also available. Home service can often be arranged through CARS or, when available, as part of a home care program. Such programs are available for patients homebound by their disease, for social reasons; for example, to mothers with young children.

In addition to physiotherapy prehospitalization, post discharge and home situation assessments are made. Aids such as raised chairs and toilet seats or bathroom rails, tongs, shoehorns etc. can be provided. Referrals to this service can come directly from the family physician.

Social Workers

This important branch of assistance to doctors is often forgotten. Families of patients with rheumatic diseases often eventually break up in the face of this chronic illness. Social workers may help to prevent this. They are also often of value in retraining, or getting the maximum allowable pensions for, crippled patients. ◀